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14 February 2009

PBC: How I cracked it

Pharmacy COPD service scores with GPs

See page 30

- **PCT commissioning crisis?**
  See pages 5 and 10
- **Yellow card reports: why bother?**
  See page 19
- **How to manage self-harm**
  See page 28

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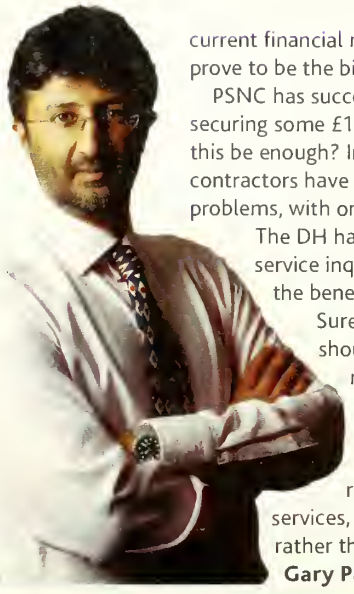
Chemist+Druggist
news education tools for the pharmacy community

Comment from the Editor

How often do you find yourself dispensing antibiotics and steroids to the same patients, week after week? And what can you do about it?

For Alan Crampsie, a community pharmacist from Durham, the solution has been a professionally rewarding one, as his journey led him to work with a PBC group to deliver a pharmacy-led COPD service (p30). Such has been the success of the initiative, it is now being rolled out to 20 pharmacies in his community.

And at a time when the news pages are full of stories highlighting the barriers that community pharmacy regularly faces, Mr Crampsie's story is a terrific example of how pharmacy can positively contribute to improving the health and wellbeing of patients. The challenge now is to ensure his success isn't a one-off.



In England and Wales, the national contractual framework promised a future of clinical services. Yes, purchase profits would be capped, but the quid pro quo was a mechanism for PCTs to make the most of their pharmacies. Well, it didn't quite work out as planned.

While the Department of Health has now set about developing PCTs' abilities to understand and utilise pharmacy services, there is a danger that the current financial mire surrounding the sector could prove to be the biggest challenge of all.

"The current financial mire surrounding the sector could prove to be the biggest challenge of all"

PSNC has successfully raised this issue with the DH, securing some £150 million of extra revenue, but will this be enough? In their evidence for the Cat M Dossier, contractors have told C+D of staff cuts and cashflow problems, with one re-mortgaging his home.

The DH has further agreed to a full cost of service inquiry, but the sector is unlikely to reap the benefits for at least a year.

Surely community pharmacy's future should lie in helping our patients get the most of their medicines and working in partnership with our healthcare colleagues – as Mr Crampsie has demonstrated. But until there is fair remuneration for NHS pharmacy services, his utopia will remain the exception rather than the rule.

Gary Paragpuri, Editor

Contents

C+D TABPI Awards 2008
Winner for news coverage

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Cat M cause of credit requests rise

Shortline suppliers report increased requests for extended credit terms due to cashflow problems

Jennifer Richardson/ Zoe Smeaton

Shortline wholesalers are feeling the effects of category M clawbacks as pharmacies default on payments due to cashflow problems, they have told C+D in response to the Cat M Dossier campaign.

Suppliers reported an increase in delayed payments and requests for extended credit terms, which pharmacy customers blamed on fluctuations in generic purchase profits.

The proportion of Elite Pharma customers paying late had risen from 20 to 35 per cent, said managing director Kirit Shah. This came at an economically unstable time when wholesalers were being hounded for prompt or even advance payment by their own suppliers, he added.

Cordia Healthcare had also experienced "concerted and sustained pressure" for extended credit during the past nine months, MD Paul Forster-Jones reported.

Shortline wholesalers have seen a rise in pharmacies seeking extended credit terms

And Colorama Pharmaceuticals MD Arun Patel said his company had increased credit control staff numbers to cope with the problem.

Contractors have echoed these problems in their own responses to C+D's campaign, to present the Department of Health with a dossier of evidence of problems caused by category M.

One contractor in Kent said bills had been left unpaid, others had dipped into savings to cover them, and some had been forced to remortgage houses or pharmacy buildings in order to get funds.

Mr Forster-Jones said the first step for contractors experiencing problems was to inform their suppliers. "Those that behave in an ethical way will find that wholesalers of repute will support them," he said.

"Other than the government radically overhauling category M – which seems at this time to be a necessity but nonetheless a forlorn hope – pharmacy needs to take control of its own destiny and liaising with their suppliers is one way to do that."

C+D's Cat M Dossier campaign began when ex-pharmacy minister Dawn Primarolo said the DH was not aware of pharmacies having problems because of the payment flow from the NHS.

Graham Phillips: pharmacists must engage with MPs

Contractors play blame game

Contractors responding to C+D's Cat M Dossier campaign this week have expressed mixed views on who is to blame for the government's apparent lack of awareness of pharmacy's category M crisis.

Cambrian Alliance said if the Department of Health was indeed unaware of pharmacy's problems, as ex-pharmacy minister Dawn Primarolo had claimed, it would "reflect badly" upon the pharmacy bodies.

And Hiten Patel, managing director of Pharma Plus, said it was "disappointing" that some of the pharmacy bodies did not seem to have highlighted the cashflow plight of members.

But PSNC chief executive Sue Sharpe told C+D the body's success in communicating the plight of contractors was "evidenced by the minister's decision... to increase funding by £150 million per annum pending a new cost inquiry".

Graham Phillips, of Hertfordshire's Manor Pharmacy Group, also defended pharmacy organisations.

He continued: "I'm not afraid to criticise the pharmacy bodies, but that doesn't mean they should always be the whipping boys."

Pharmacists themselves must continue to engage with MPs as much as possible to make their case heard, he added. **ZS**

CAT M DOSSIER

Have you found pharmacy funding erratic since category M was introduced? ☐ YES ☐ NO

Has your pharmacy had any problems as a result of payment flows from the NHS? ☐ YES ☐ NO

If yes, in what ways has your pharmacy been affected?

Name, pharmacy and pharmacy address

Complete the slip and return it to us at: C+D, Cat M Dossier, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE or fax to 01732 367065 or email to haveyoursay@cmpmedica.com DEADLINE EXTENDED TO FEBRUARY 21

PCT accountability fears

Sandra Gidley MP raises doubts over monitoring of PCT commissioning

Zoe Smeaton

PCTs will not be sufficiently held to account if service commissioners fail to engage with pharmacy, experts fear.

The NPA and Sandra Gidley MP have both expressed concerns over the management of PCT performance. They were not confident the trusts would be monitored adequately, they said.

The comments followed a meeting of the all-party pharmacy group, where delegates discussed how strategic health authorities could help PCTs to factor community pharmacy into commissioning arrangements.

Pharmacist Ms Gidley told C+D after the meeting she was not confident PCTs would be held to account. PCT guidance on engaging with pharmacy, expected to be released in March, could help, she said, but "only if we can find a way to use it". Otherwise it would just "gather dust on some SHA member of staff's shelves", she warned.

NPA head of external relations Stephen Fishwick said "questions" remained over the capacity and experience PCTs had to work with pharmacy on commissioning.

The NPA was "not confident that there is sufficient leadership or leverage within the performance management process", he added.

A DH spokesperson said the expected guidance would give PCTs the skills to commission services.

World class commissioning – where are we now? **See page 10**

NPA: profession at disadvantage

Pharmacists could be at a disadvantage when competing with other providers to get services commissioned, the NPA has warned.

The association has lodged its concerns with the newly formed NHS Co-operation and Competition Panel. This is working to ensure that rules for NHS funded services support the delivery of high quality care and value for money for taxpayers.

One issue was pharmacy's lack of access to care records, which NPA head of external relations Stephen Fishwick said "potentially limits the scope for the commissioning of integrated pharmacy services in an NHS environment".

Fin McCaul, chairman of the Independent Pharmacy Federation, agreed: "Pharmacists are at a disadvantage for many reasons; summary care records access is one."

Pilots to consider community pharmacist access to summary care records were "still at a very early stage", Connecting for Health said. It added that current emphasis was on establishing the records in GP practices.

Wholesaler conventions scrapped

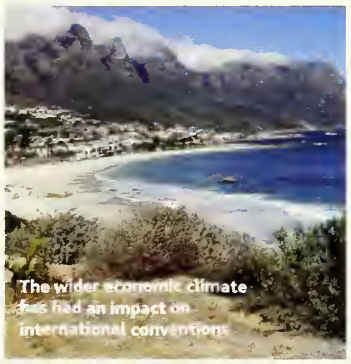
AAH and UniChem will not run international conventions in 2009 as has previously been the tradition.

Past conventions have seen contractors and suppliers mixing in locations such as Cape Town and Barbados, and pharmacists contacted by C+D said they were disappointed at the news.

AAH said it would instead run a series of customer events in the UK. The decision came in response to feedback from customers and suppliers, and the new format was "more appropriate given the current economic climate", the wholesaler said.

UniChem has postponed its convention, scheduled to take place in September in Sardinia, after "extensive consideration of all alternative options".

The recent drop in the value of the pound had increased costs by an unprecedented amount, the wholesaler said. **ZS**



The wider economic climate has had an impact on international conventions

Emergency supply extension proposed

Pharmacists could make an emergency sale or supply of certain prescription-only medicines for up to 30 days' treatment under new proposals.

The plans are part of an MHRA consultation on the manufacture, distribution, sale and supply of medicines and devices during an influenza pandemic, and emergency supply of medicines in general.

One proposal would extend the period for which pharmacists, at their own professional discretion and a patient's request, could make an emergency sale or supply of specified POMs from five to 30 days, not only during a flu pandemic.

In terms of influenza, the medicines watchdog wants pharmacists to be able to supply certain POMs without a prescription and not necessarily from pharmacy premises.

Pharmacists would no longer have to interview a person requesting an emergency supply of medicines during a pandemic, which would also allow supply of expired and returned medicines and greater flexibility in relation to controlled drugs.

The consultation closes on March 20. **EW**

News in brief

No UniChem fuel levy

UniChem will not implement a fuel surcharge for March. The levy has not been removed indefinitely, and the position will be reviewed on "a month by month basis". The fuel surcharge reference will still appear on March UniChem statements, but will state £0.00.

PPRS price delay

AAH is maintaining old PPRS trade prices on some Napp products until stock has been sold. The news came as UniChem announced it had moved to the reduced prices, which came into effect on February 1, on all but 36 products, from one supplier. www.chemistanddruggist.co.uk

Adherence guide out

A guide for pharmacists on the new Nice guideline on medicines adherence has been released by the RPSGB. The two-page quick reference sheet covers how to implement the guideline and summarises key action points. http://tinyurl.com/byl829

Charter consultation

Pharmacists have been called upon to comment on potential changes to the RPSGB's Royal Charter. The consultation, which will run until May 7, results from the separation of the regulatory and professional functions of the Society. See www.rpsgb.org

AAH clarifies policy

AAH has clarified its specials charging policy after some customers experienced "inconsistencies". AAH confirmed it would charge a 20 per cent handling fee with a minimum of £9 and a maximum of £45 per invoice processed. But it warned that a single customer order for several products could generate more than one invoice for AAH. www.chemistanddruggist.co.uk

Cegedim EPS hope

Cegedim Rx is hoping its Electronic Prescription Service (EPS) software will be accredited for release 2 of the service by the end of February. MD Simon Driver told C+D Connecting for Health's testing process had been "painful" but that he expected to be ready in a "couple of weeks, touch wood". www.chemistanddruggist.co.uk

News in brief

NCSO update

The Department of Health and National Assembly for Wales have agreed to allow NCSO endorsements for the following items for February prescriptions: cimetidine 400mg tablets and hydroxyzine 25mg tablets.

Scottish preparation fees

The Scottish Government has unveiled details of the next strand of this year's contract preparation payments. Pharmacies will be paid £900 each for completing a week-long (March 16 to 22) audit of problems with prescriptions. Claims must be made by April 30. http://tinyurl.com/an92eq

Minor ailments demand

There has been a significant increase in the number of people seeking pharmacist advice and treatment for minor ailments, Lloydspharmacy has said. Sixty per cent of pharmacists surveyed by the company reported an increase in customers seeking minor ailments advice in the past six months. www.chemistanddruggist.co.uk

Alcohol campaign backed

The Department of Health has published an activity pack for pharmacists for its Know Your Limits alcohol awareness campaign, available at www.pcc.nhs.uk. Chief pharmaceutical officer Keith Ridge has also asked PCTs to choose the campaign as a topic for community pharmacy public health campaigns.

Key to CVD strategy

Pharmacy-based services must be fully integrated into primary care in order to meet the Cardio & Vascular Health Coalition's 2010-20 targets for developing services for heart disease, stroke, diabetes and kidney disease, the NPA has said. www.chemistanddruggist.co.uk

Pregnant smokers role

Pharmacies have a vital role to play in helping pregnant women to quit smoking, the NPA has said. The comments follow research that found pregnant women are reluctant to seek help to stop smoking because they worry about the reaction of health professionals. www.chemistanddruggist.co.uk

Rowlands pharmacist is weight loss leader

Customers have lost an average of two stone each in Celebrity Slim programme

Emma Wilkinson

A Rowlands pharmacist is leading by example when it comes to encouraging his customers to lose weight.

Using the multiple's Celebrity Slim meal replacement programme, Angus McLagan has lost more than three stone in eight weeks.

He decided to take up the challenge when he went on the Celebrity Slim training course in November, as other diets had not worked for him in the past.

Customers who have signed up to Celebrity Slim in Mr McLagan's Barnsley branch have lost a total of 9.5 stone. The scheme costs £25 a week for milkshakes, soups and snack bars.

In total, Rowlands Pharmacy customers, who get a free initial consultation and weekly weigh-ins, lost four tons in January, bringing their average so far to two stone each. The scheme was rolled out at the end of last year.

Celebrity Slim dieters replace two meals with the supplements and have a normal, but low-carbohydrate, evening meal as well as three snacks a day.

"I have tried a few things in the past but the weight always seems to come back on," said Mr McLagan. "I'm not missing anything and I'm eating more vegetables."

It helped that he and the customers were all in it together, he said. "We can share meal ideas," Mr McLagan added.

C+D gained an unusual fan last week – a 6ft snow-pharmacist. This boost to our readership was created by the team at Boots's Burnham branch as the country stuttered to a halt under the worst snowfall for almost two decades. Pharmacist Bobby Mehta (pictured left, with trainee dispenser Josie Aldridge, right) thanked delivery driver Ray Smith (just seen behind) for holding up C+D for the snowman to read. "What pharmacist could possibly be seen without the one and only C+D?" asked Mr Mehta. "He seemed fascinated, ironically, by the edition with the front cover headline regarding climate change!"

Has your pharmacy been hit by flooding this week? haveyoursay@cmpmedica.com

Differential fees warning from NPA

Government proposals must not act as a deterrent to innovative pharmacy services, the NPA has warned.

Department of Health plans to empower the future pharmacy regulator to set differential fees need "careful consideration", NPA chairman Paul Bennett said.

The proposals in the draft Pharmacy Order would enable the General Pharmaceutical Council (GPhC) to "set fees that relate to the scale and/or scope of the activities carried out at the premises".

But Mr Bennett said: "It would be completely unacceptable if those who offer clinical services are penalised for their innovation."

The NPA would make strong representation on the GPhC's remit, Mr Bennett added. Other concerns included the need for community pharmacy representation on the Council, and the potential for duplication of regulatory burden through existing inspection, such as that carried out by primary care organisations.

The draft Pharmacy Order is under public consultation until March 9. **CC**

Available from 1st March 2009

When hayfever strikes, Nasacort sticks

Nasacort Allergy is now available for pharmacy. Its thixotropic[1], once-a-day formulation stays where it's sprayed for maximum effect against hayfever symptoms – and with no strong odour or taste, patients prefer it over Beconase® and Flixonase®[2,3]. Give them Nasacort and help avoid problems whenever hayfever's around. For more information about Nasacort Allergy, and copies of training materials and point-of-sale items, please contact your local Laser Healthcare Pharmacy Business Manager or call 01202 780558.

Stays where it's sprayed

NASACORT ALLERGY NASAL SPRAY PRESCRIBING INFORMATION

Presentations: Each bottle of Nasacort Allergy Nasal Spray contains 3.575 mg triamcinolone acetonide and provides at least 30 actuations each containing 55 micrograms of active compound after initial priming. **Indications:** Treatment of the symptoms of seasonal allergic rhinitis. **Dosage and Administration:** Patients aged 18 years and over: recommended dose is 220 micrograms as 2 sprays in each nostril once daily. Once symptoms are controlled patients can be maintained on 110 micrograms (1 spray in each nostril once daily). The minimum effective dose should be used to ensure continued control of symptoms. Children: not recommended for children or adolescents under 18 years of age. Medical advice should be sought if symptoms worsen or persist after 14 days treatment. **Contraindications:** Hypersensitivity to any of the ingredients of this preparation or an infection in the nose. **Warnings and precautions:** impaired adrenal function, patients taking steroids should consult their doctor before using this product, recent nasal surgery or prolonged nose bleeds, pregnancy or lactation. There are rare reports of localised candida albicans infections in which case product should be discontinued and appropriate therapy instituted. This product should not be used for longer than 3 months without consulting a doctor. **Side-effects:** The most commonly reported adverse reactions are rhinitis, headache and pharyngitis. Respiratory disorders: epistaxis, nasal irritation, dry mucous membrane, nasosinus congestion and sneezing; rarely, nasal septal perforations. In clinical trials these adverse reactions with the exception of epistaxis, were reported at approximately the same or lower incidence as placebo treated patients. Skin or subcutaneous disorders: rarely allergic reactions including rash, urticaria, pruritus and facial oedema. Systemic effects of nasal corticosteroids may occur, particularly when prescribed at high doses for prolonged periods. **Legal Category:** P

Product Licence Number: PL 04425/0605 **Recommended selling price:** £4.95. **Refer to Summary of Product Characteristics for full prescribing information. Further information is available from the Marketing Authorisation holder: sanofi-aventis, One Onslow Street, Guildford, Surrey, GU1 4YS. Date of Revision of Prescribing Information: October 2008.**

References: 1. Nasacort Summary of Product Characteristics, May 2008. 2. Lumry W et al. A comparison of once-daily triamcinolone acetonide aqueous and twice-daily beclomethasone dipropionate aqueous nasal sprays in the treatment of seasonal allergic rhinitis. Allergy Asthma Proc 2003;24(3):203-10. 3. Stokes M et al. Evaluation of patients' preferences for triamcinolone acetonide aqueous, fluticasone propionate, and mometasone furoate nasal sprays in patients with allergic rhinitis. Otolaryngol Head Neck Surg. 2004; 131(3):225-31.

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Date of preparation: November 2008. NAS 08/1001

Dispensary TALK

Did your pharmacy build a snowman?

"We would have loved to, but we were the only pharmacy open for about a mile around. I saw three lads who had built a snowman with lips and button detail, so some people were really industrious!"
Raj Rohilla, Richmond Pharmacy, Surrey

"There wasn't enough snow immediately available to do it. We're in a small village and the pavements and roads were reasonably well trampled in by traffic or salted by the time we got here. It would have been nice to stay at home and do it."
Kevin Western, Day Lewis, Coggeshall, Essex

WEB VERDICT:

Yes and staff had a snowball fight	17%
Yes	4%
No, but I made one at home	28%
No	51%

Armchair view: The rest of the country might have been playing in the powder last week, but our poll suggests many pharmacies were too snowed under to join in the fun.
Next week's question: Have you seen an increase in customers seeking minor ailments advice?
www.chemistanddruggist.co.uk

Pharmacist with drink problem struck off

St Helens manager also self-administered medicines, RPSGB hearing finds

A former St Helens pharmacy manager with a drink problem who self-administered medicines has been struck off.

Karen Stewart, 54, of St Helens, had identified her problems, the Royal Pharmaceutical Society hearing was told.

However, striking her off, panel chair Patrick Milmo QC said that her actions were "premeditated" and involved "temporary concealment" by creating computer records of tablets taken.

He added that, although she had recognised her underlying health difficulties, that had only been a "recent" insight. "You owe it to yourself to confront and cure your problems," he told her.

The panel had been told that, by not reporting that she may not be fit to practise, Ms Stewart had "failed to act quickly to protect patients and the public from risk".

Ms Stewart worked as a locum in a Lloydspharmacy in Rainhill and at the Co-operative Pharmacy, Cowley Lane Hill, St Helens. She was a pharmacy manager at Tims & Parker, Culceth.

The hearing was told that, between October 31, 2004 and September 1, 2006, her "breath smelt of alcohol while working as a pharmacist" and she had been drinking "up to one bottle of wine a day or up to two bottles of vodka a week at times other than when working".

Ms Stewart has three months to appeal. **UKL**

PSNC deflects counterfeit blame

PSNC has defended the sector following news reports of thousands of patients having taken dangerous fake drugs handed out by pharmacies.

Pharmacists could not be held accountable for this, said PSNC chief executive Sue Sharpe.

The contract negotiator's comments were prompted by the newspaper Metro's coverage of a BBC File on 4 investigation into counterfeit medicines.

On the programme, an MHRA representative said that around 30,000 fake packs of Casodex, Plavix and Zyprexa got into the hands of patients through pharmacies after a recall in June 2007.

But it was almost always impossible for pharmacies to identify counterfeit medicines, said Ms Sharpe. "The requirements for labelling of medicines imported from other European countries lead to repackaging and this inevitably introduces a risk.

"If a patient has any reason to believe a medicine could be a counterfeit, it is important to take it to a pharmacy as soon as possible."

PSNC was supporting work by the MHRA to improve controls on medicines distribution and minimise the risks of counterfeit medicines entering the UK supply chain, Ms Sharpe added.

The NPA would also be responding to the MHRA consultation on the integrity of the medicines supply chain, spokesperson Neal Patel said. **EW**

Pharmacist pleads guilty to script fraud

A pharmacist honoured by the Queen has pleaded guilty to two fraud offences amounting to tens of thousands of pounds of NHS funds.

Dr Hooman Ghalamkari, who was awarded an MBE for services to pharmacy, admitted theft of prescription charges and falsifying documents used for accounting while running his two pharmacies, the NHS Counter Fraud Service said.

Mr Ghalamkari had been dispensing generic simvastatin to patients who presented with a script for Simvador, and then claiming for the branded drug. His pharmacy also endorsed scripts as exempt from charges, after they had been paid for.

The case sent out "a strong message of deterrence to others who may be tempted to steal from the NHS", said Dermid McCausland, managing director of the NHS Counter Fraud and Security Management Service.

"The crime of fraud can be committed by those we least expect," Mr McCausland added.

Since his arrest, Dr Ghalamkari has sold his pharmacies and paid back £27,000. He will be sentenced on March 6. **CC**

Forecast a rosier outlook this winter with spoonfuls of TLC from Care.

When winter comes coughing and spluttering through the door, your customers need all the help they can get. Care is now the second biggest brand sold into UK pharmacies[1] - and still growing. So whether it is for a sore throat, a blocked nose or a cough, you can offer your customers all the TLC they need this season from the Care Winter Remedies Range.

Care+™

All the care you need.

1. . IMS Volume data (MAT June 2008) and Care ex factory volume (MAT June 2008)

Pharmacy will be the real winner if world class commissioning can be realised. But PCTs will have to raise their game to achieve this goal, finds the CCA's **Georgina Craig**

A question of class

This government's philosophy on healthcare has always been that local is best. And that is no longer just rhetoric. The 152 PCTs across England now hold over 80 per cent of the NHS budget, and the commissioning decisions they make impact directly on the health and wellbeing of their local population. Yet, despite a doubling in NHS expenditure and reductions in waiting times, significant health inequalities persist and the quality of NHS services remains unacceptably variable.

Independent watchdogs such as the Audit and Healthcare Commissions have questioned PCTs' capabilities and whether policies such as practice-based commissioning (PBC) are working. Most recently, the House of Commons Health Committee published its first report from its inquiry on the NHS Next Stage Review, which makes uncomfortable reading for both PCTs and strategic health authorities alike. It recognises that successful delivery of the Next Stage Review lies in the hands of PCTs, but the committee said it "doubts that most PCTs are currently capable of doing this task successfully".

The select committee added that both itself and the government acknowledge PCT commissioning is poor. In particular, PCTs' lack of analytical and planning skills, the variable quality of managers and the absence of strong clinical leadership at local level are areas of concern.

To help address this, the government launched its World Class Commissioning programme in July 2007. But its impact has been limited to date. Now, nearly 18 months on, the seeds of change are just starting to germinate. Yet the real question – whether or not PCTs can prevent the pressure of professional politics engulfing their commissioning processes – remains unanswered. And the early signs are not good.

The Health Committee believes that GP federations (collections of GP practices that work together virtually to provide services across a PCT) are being given preferential treatment in tendering processes for GP-led health centres, and that commercial providers are losing their nerve and quitting the primary care market as GP protests grow and the credit crunch starts to bite.

Early feedback also suggests that PCTs are already defaulting to general practice as their main provider for vascular risk assessments – despite the Prime Minister's promises that pharmacy would be an integral part of service provision. PSNC is, of course, working hard behind the scenes to level the playing field for pharmacy, but it should not need to do that. It should be a given – or even a directed enhanced pharmacy service – if the government's resolve to broaden the primary care provider base really is that strong.

At both national and local level, pressure to maintain the status quo persists. It has become endemic in the NHS, and it is one of the biggest barriers that pharmacy faces as it works to expand its role. Addressing it will require massive cultural change, something that takes lots of high quality management time and effort. And, as the Health Committee has pointed out, the NHS simply does not have that at its disposal.

Against this challenging general background, what do we know about pharmacy commissioning specifically?

The white paper told us that the government has concluded that PCT commissioning competence for pharmacy was "not yet at a stage where PCTs can be charged with full responsibility for contracting". The pharmacy white paper, the all-party pharmacy group inquiry and the Galbraith Review all recognised that pharmacy commissioning remains patchy and inconsistent. And the statistics suggest that, since local services were rebranded as enhanced services in April 2005, there has been little growth in the overall number commissioned. In fact, anecdotally, many PCTs are decommissioning pharmacy services – even where they are proving popular with patients.

For pharmacy businesses, local enhanced services still remain a tiny source of income and, with the added concern about unpredictable PCT commissioning, they are far from being a core source of income for most pharmacy businesses.

Robust pharmaceutical needs assessments (PNAs) – the cornerstone of successful local pharmacy commissioning – are also in need of a massive injection of management effort to make them fit for purpose. Recent NHS Employers guidance for PCTs paints a picture of a joined-up PNA process that would go a long way to integrating community pharmacy into primary care. But, like all NHS policy these days, successful local implementation will be key, and that will not happen unless PCTs prioritise PNAs and invest in the pharmacy commissioning process more generally.

It seems the ball is firmly in the PCTs' court to deliver, but they cannot do it alone. In part two of this series next week, we will look at what contractors and pharmacy employees can do at local level to drive change and partner effectively with PCTs to deliver better pharmacy-based care for customers.

Commissioning and PCTs – what's your experience been?
haveyoursay@cmpmedica.com

LETHAL OBSESSION

Weight loss is a vital part of cardiovascular risk management and weight loss with Xenical can have a significant impact upon key risk factors.[1-5] When you help change their weight, you help change their future.

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Please contact Roche Drug Safety Centre on: 01707 367554

Roche

PRESCRIBING INFORMATION. XENICAL (orlistat). Indications: XENICAL is indicated in conjunction with a mildly hypocaloric diet for the treatment of obese patients with a BMI ≥30 kg/m², or BMI ≥28 kg/m² with associated risk factors. Treatment should be discontinued after 12 weeks if patients have been unable to lose ≥5% of their body weight. **Dosage and administration:** One capsule immediately before, during or up to one hour after meals (only 30% of calorie intake from fat). **Contra-indications:** Chronic malabsorption syndrome, cholestasis, breast-feeding, known hypersensitivity to any component of the product. **Precautions:** Monitor anti-diabetic drug treatment. Co-administration of orlistat with ciclosporin is not recommended. Treatment may potentially impair the absorption of fat-soluble vitamins (A, D, E, and K), patients should be advised to have a diet rich in fruit and vegetables. The possibility of experiencing gastrointestinal events may increase when orlistat is taken with a diet high in fat. Caution should be exercised when prescribing to pregnant women. Studies have shown no interaction between orlistat and oral contraceptives, however an additional contraceptive method is recommended to prevent possible failure of oral contraception that could occur in case of severe diarrhoea. Rare cases of rectal bleeding, generally of mild intensity have been reported and prescribers should investigate further if symptoms are severe or persistent. **Drug Interactions:** A decrease in ciclosporin levels has been observed in an interaction study. Co-administration with acarbose should be avoided. INR values should be monitored if patient is on warfarin or other anticoagulants. Reinforcement of clinical and ECG monitoring is warranted if patient is on amiodarone. **Side-effects:** Please consult the Summary of Product Characteristics for full details of adverse events. **Common:** Influenza, anxiety, headache, respiratory infection, urinary tract infection, menstrual irregularity, fatigue and gastrointestinal such as oily spotting, abdominal pain, increased defecation and flatulence. Treatment adverse events in type 2 diabetics included hypoglycaemia and abdominal distension. The incidence of adverse events decreased with prolonged use of orlistat. **Serious:** Very rare cases of increases in liver transaminases and alkaline phosphatase and also cases of hepatitis. Very rare cases of bullous eruptions, diverticulitis and cholelithiasis. Rare hypersensitivity reactions of angioedema, bronchospasm and anaphylaxis. **Legal Category:** POM. **Presentation and Basic NHS Cost:** Xenical 120mg (84 capsules) £33.58. **Marketing Authorisation Number:** EU/1/98/071/003 (84 capsule blister pack). **Marketing Authorisation Holder:** Roche Registration Limited, 6 Falcon Way, Shire Park, Welwyn Garden City, AL7 1TW, UK. Further information is available on request. Xenical is a registered trade mark. **Date of preparation:** June 2007.

References: 1. Hollander PA et al. Diabetes Care 1998; 21: 1288-1294. **2.** Hanefeld M and Sachse G. Diabetes Obes Metab 2002; 4: 415-423. **3.** Sharma AM and Golay A. J Hypertens 2002; 20: 1873-1878. **4.** Broom I et al. Br J Cardiol 2002; 9: 460-468. **5.** Torgerson JS et al. Diabetes Care 2004; 27: 155-161.

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J9792055T August 2008.

Farida Sharafali explains the latest changes to the RPSGB's CPD requirements

Your guide to CPD

What is CPD?

The RPSGB's Medicines, Ethics and Practice says: "Continuing professional development (CPD) is a framework for the maintenance of professional competence. It is a cyclical process of reflection on practice, planning, action and evaluation (reflection on learning)."

What's new?

Last week the RPSGB Council agreed that, as of March 1, it will be mandatory for practising pharmacists and registered technicians in England, Scotland and Wales to record a minimum of nine CPD entries each year. Until that date there had been no official mandatory standards or guidance under the Code of Ethics regarding CPD records.

Why has it been introduced?

Previously, the RPSGB Council had suggested a minimum in the range of six to 12 CPD entries per year. However, this has led to confusion, with some interpreting six as a lower limit and 12 as a higher limit. Indeed, some members were concerned that too many entries would result in sanctions. By setting the minimum as nine CPD entries per year the Council hopes to clarify the position, but urges members to exceed the minimum.

Why is it happening now?

The Society is trying to encourage members to make CPD entries before the statutory CPD assessment process is introduced in April 2010, with the establishment of the General Pharmaceutical Council (GPhC). The Society is developing transitional arrangements, to enable CPD records created before the statutory requirements are in place to form part of the assessment process.

How does it affect me?

The Society says that by highlighting the CPD requirements, it is showing the profession what standards it needs to attain. If you're a part-time worker, the same rules apply – nine records every 12 months.

What should I do?

It's a good idea to get into the CPD habit before it becomes statutory in April 2010. The Society's target is to encourage members to make one entry every month, taking into consideration a few months' records may be missed due to illness, busy periods and holidays.

Mandatory or statutory?

Mandatory means compulsory. Statutory has legal connotations.

What if I don't do anything?

This summer the Society will begin a system of 'call and review', whereby the CPD records of each registered practising pharmacist and pharmacy technician will be periodically checked by the Society.

If they fail to respond to a request and two reminders to submit their CPD record for review, or if they have responded but do not submit a CPD entry, it would be considered a breach of the Code of Ethics. This could result in the Society's Fitness to Practise procedures. However, the RPSGB Council also agreed last week that non-compliance with the new requirements would not be referred to the Investigating Committee, subject to threshold criteria.

What will happen next year?

2010 will lead to a new era in pharmacy, when the GPhC will be formed and statutory CPD assessment will be enforced in the April of that year. After this, it will be the responsibility of the GPhC to set out a framework and criteria, which will be announced later in the year.

How do I make entries?

Currently, CPD entries can be made online or on paper. However, due to the implications of cost, difficulty in transferring records, problems with legibility, staff time and several other reasons, the Society wants members to submit online CPD records. CPD facilitators are exploring ways in which electronic submissions are made easier. CPD records on paper will continue to be accepted without any additional fees when routine CPD reviews commence. Members submitting paper entries will receive the same full review and feedback service as those who submit electronic records.

What are the key dates?

March 1, 2009	Mandatory to make nine CPD entries per year
April 2010	Statutory CPD assessment will be enforced

Need help with CPD?

Try C+D's Clinical Update series – complete the online 5 minute test and get an RPSGB approved CPD log sheet.

See p20 for details

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FULL ESSENTIAL INFORMATION FOR NUROFEN EXPRESS 200MG LIQUID CAPSULES Name: NUROFEN Express 200mg Liquid Capsules Ibuprofen. **Indications:** Adults and children over 12 years: Ibuprofen 200mg Liquid capsules are indicated for the symptomatic relief of rheumatic or muscular pain, backache, neuralgia, migraine, headache, dental pain, dysmenorrhoea, feverishness colds and influenza symptoms. **Dosage and Administration:** For oral administration and short-term use only. During short-term use, if symptoms persist or worsen the patient should be advised to consult a doctor Adults and children over 12 years: Initial dose two capsules taken with water, then if necessary, one capsule every four hours. Do not exceed six capsules in any 24 hours. Not for use by children under 12 years of age without medical advice.Elderly: No special dosage modifications are required. (See Section 4.4) The minimum effective dose should be used for the shortest time necessary to relieve symptoms. If the product is required for more than 10 days, or if the symptoms worsen the patient should consult a doctor. **Contraindications:** Patients with a known hypersensitivity to ibuprofen or any other constituent of the medicinal product.Patients with a history of bronchospasm, asthma, rhinitis, or urticaria associated with aspirin or other non-steroidal anti-inflammatory drugs (NSAIDs). Patients with a history of, or existing gastrointestinal ulceration/ perforation or bleeding, including that associated with NSAIDs. Patients with severe hepatic failure, severe renal failure or severe heart failure. See also Section 4.4 Use with concomitant NSAIDs, including cyclo-oxygenase-2 specific inhibitors – increased risk of adverse reactions. During the last trimester of pregnancy as there is a risk of premature closure of the fetal ductus arteriosus with possible persistent pulmonary hypertension. The onset of labour may be delayed and the duration increased with an increased bleeding tendency in both mother and child. Severe heart failure. **Precautions and Warnings:** Caution in patients with certain conditions, which may be made worse. Systemic lupus erythematosus and mixed connective tissue disease, gastrointestinal disorders and chronic inflammatory intestinal disease, hypertension and/or cardiac impairment, renal impairment, hepatic dysfunction. High doses / long term treatment is associated with increased risk of myocardial infarction. Bronchospasm may be precipitated in patients with bronchial asthma or allergic disease. GI bleeding, ulceration or perforation. Caution in patients on medications which increase the risk of gastrotoxicity or bleeding. If GI bleeding or ulceration occurs, stop treatment. The elderly are at increased risk of the consequence of adverse reactions.Female fertility may be impaired by a reversible effect on ovulation. Side effects: In short-term use, at OTC doses, adverse effects are uncommon or rare. They include abdominal pain, dyspepsia and nausea. Hypersensitivity reactions are uncommon, and may include non-specific allergic reactions, anaphylaxis, respiratory tract reactivity (e.g. asthma, bronchospasm) and various skin reactions (e.g. pruritus, urticaria, angioedema). For a full list of potential adverse events, see the Summary of Product Characteristics.
Product licence Number: PL 00327/0202 **Licence Holder:** Crookes Healthcare Limited, Nottingham NG2 3AA. **Legal category:** GSL **RSP:** £3.92 for 16 liquid capsules **Date of Prescribing Information:** January 2009.

Information about adverse event reporting can be found at www.yellowcard.gov.uk Adverse events should also be reported to the Medical Information Unit, Reckitt Benckiser, Hull. (0500 455 456).

Xrayser

What's your view? haveyoursay@cmpmedica.com

All loved up on Valentine's Day

Happy Valentine's Day, Mr Churton – I think I'm falling in love. Our current love-in, in which you profess to care about and understand me, makes me feel so special. I feel wanted by the Society for the first time ever, and am compelled to join your new professional body so you can protect me from the nasty looking professional regulator that's shaping up in the other corner.

I'm getting used to seeing your friendly face and touchy feely words of support at least once a week. We even seem to be on first name terms these days. Your 'workplace pressure' initiative is the first time that the Society has acknowledged that I may be under any pressure at all. In fact, the 'old' Society was probably a cause of some of these pressures.

You and your team have probably done more 'listening' over the last few months than the Society has in its entire 168-year history. The Clarke Inquiry, TransCom, market research, membership surveys and face-to-face meetings must have produced enough moans and groans to last the new professional body for the next 168 years.

"It is simply not acceptable, or safe, for pharmacists to work without appropriate support, or the ability to take rest breaks," you say in your recent open letter. You are truly a man after my own heart. I can't wait to enjoy my daily tea and biscuit in a comfy chair.

You're concerned about my stress levels and that I might become depressed. And you're going to help me delegate some of my workload. Great news, but don't expect to undo all your predecessors' efforts overnight. Just make sure you're ready to stand up for me against the GPhC when it is launched next year.

This panel of mostly non-pharmacists will be set up to protect patients' interests (C+D, February 7, p10), whatever they might be at the time. The head of the CHRE recommends that every minor misdemeanour we ever commit is carved for ever in stone on the Register (C+D, February 7, p12). He even mentions putting adverts on the side of buses, encouraging the public to phone in with comments on our performance. Can he be serious?

> "I want to complain about that difficult man at the chemists. He refuses to give me my favourite brand of tablets"

I can imagine my patients ringing in now: "Hello, Mrs Whingebag here – I want to complain about that difficult man at the chemist. He refuses to give me my favourite brand of tablets, says that's what the doctor ordered. Can you strike him off please?" Or: "Attention! Brigadier Painin thearse speaking. That chemist kept me waiting for two minutes and 42 seconds last week. He needs court martialling."

These last few months of the good cop, bad cop routine at Lambeth could be testing for all concerned. Let's hope the good cop wins. I want this wonderful feeling of lurrvve to continue for as long as possible.

Pharmacist in the House

Sandra Gidley

Opportunities knock, so open your pharmacy's doors

Everybody but the previous minister for pharmacy knows that times have been difficult for community pharmacists and that it has been difficult for businesses to make ends meet.

The credit crunch has had a visible effect on the high street as businesses have closed down and no new business has moved into the empty property. In small towns the consumer now has a limited product range to choose from.

But I sometimes wonder if businesses are doing all they can to help themselves. For example, in my home town the local supermarket stopped selling DVDs about the same time as Woolworths closed. Now there is nowhere in town to buy a DVD.

I am not suggesting that pharmacy should fill that particular gap, but if the government is not going to adequately finance the profession then maybe community pharmacists need to look for other opportunities to generate business and income.

Now, the profession may be missing a trick or two anyway. A baroness recently told me that she had been impressed by what she had heard about pharmacies providing new services so she conducted a fairly random search to try and discover what was happening in a pharmacy near her. The answer seemed to be pretty much nothing.

> "The baroness conducted a random search of pharmacies for new services"

But before we start blaming commissioners for not paying for services we could provide, perhaps we should take a long hard look at the face community pharmacy presents to the high street.

Dare I suggest that it is quite a girlie sort of face? Window displays often promote the cosmetics and toiletries side of the business and it is not uncommon, upon entering a pharmacy, to have to stumble over soft toys and general kitsch before accessing the pharmacy counter.

I must admit that I liked that side of the business and so did my predominantly female staff, but there was nothing to attract the average man. Yet research shows that men like the fact they can drop into a pharmacy on a casual basis so how can pharmacies become more welcoming places?

Start thinking about it because Men's Health Week is in June this year and the theme is access to services. Why not register on the website and get involved? After all, if you are currently neglecting half of the population then it might even be good for business.

Sandra Gidley, Lib Dem MP and shadow health spokesperson

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Version no. 04263

Letters

Please email us with your letters including your name, address and contact number to: **haveyoursay@cmpmedica.com**
Or write to the Editor at:
C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE
Letters may be edited for content and length

Let's reform codeine sales

I am very much in favour of reforms in the sales of OTC codeine-containing drugs. I am even in favour of making them POM.

These are some of the reasons:

Codeine 8mg has little analgesic effect, so there is little additional benefit from its inclusion in OTC products for analgesia.

I have a patient recently started on subutex due to codeine addiction.

Another patient ended up with kidney failure due to excessive consumption of an OTC product containing both ibuprofen and codeine.

We have had to restrict sales of this product to the pack size of 12 for the majority of customers.

Eoghan O'Brien, Bannside Pharmacy, Portglenone

Problems with ETP raise concerns for pharmacy

I agree with Bob Dunkley in his letter published in C+D (January 31, p28). He makes a lot of sense and says it better than I do.

What surprises me is the total lack of positive response to the various articles on ETP (not just in C+D). There seem to be no pharmacists out there who are using the system and using it successfully.

> "There seem to be no pharmacists out there who are using the [ETP] system and using it successfully"

I think that there is such a variety of functionality with the various suppliers and this is one problem; we are not comparing like with like.

In the last month, I have spent two weeks trying to log onto the system and talking with my helpdesk, who were very helpful. I sent my smartcard back to the PCT who checked and said that it was working satisfactorily. On return it would not work again, giving strange error messages, but after several days – out of the blue – it started to work. This erratic (and unexplained) behaviour is what I fear. With release 2, we will have no back up of paper scripts, just patients going to the next pharmacy to get their scripts downloaded and not coming back!

I seem to be one of the few pharmacists, along with Bob Dunkley, who seem to be interested in ETP and actually using it, but we just see the flaws and problems. Most other pharmacists have no interest and believe that 'It won't happen in my lifetime!'.

Peter McAuley MRPharmS, Highworth, Swindon

Are you successfully using ETP?
haveyoursay@cmpmedica.com

How can restrictions safeguard availability?

I read the article in C+D (January 31, p7) about Pfizer's auditors looking at pharmacies with high orders for Pfizer stock, and wanted to make a comment about how this seems to be done without thought or discretion.

We regularly receive signed orders from a local surgery and a family planning clinic for Depo-Provera, the injected long-acting reversible contraceptive. Being in Bristol – a city with a high teenage pregnancy rate and areas of urban deprivation – it's used a lot. We probably get requests to supply about 20 a month, sometimes 40.

Pfizer is now refusing to supply to us, even though I have explained the reason for our purchases. I offered to send them copies of the signed orders as proof – but still they refused. Their answer was the clinics should use another supplier!

How can this 'protectionist' action be defended? What happened to open access of supply? These clinics need these drugs for UK NHS, so how does restricting our supply "safeguard the availability"?
Chris Howland-Harris, Ashgrove Pharmacy, Bristol

> "How can this 'protectionist' action be defended? What happened to open access of supply?"

Pfizer responds...
Pfizer understands that specific customer concerns relating to the supply of Pfizer prescription medicines, in particular Depo-Provera, have been brought to the attention of C+D.

For Pfizer it is critical that every UK pharmacy is able to buy supplies of our medicines to meet their patient needs.

For a small number of Pfizer medicines (including Depo-Provera), we operate a different supply model to that of our standard distribution arrangement. This applies typically to those medicines that are used in specialist clinics and/or GP surgeries that require administration by a healthcare professional.

In England and Wales, we use our specialist distributor Williams Medical Supplies to deliver direct to GP surgeries and clinics, where healthcare professionals can administer this important medication to their patients.

In addition, Depo-Provera is also available to pharmacies via our logistics service provider, UniChem. As with all orders, we monitor highly irregular or unusual requests that may compromise our ability to ensure continued availability to all UK patients.

If pharmacists have any concerns regarding our distribution arrangement, they should contact the Pfizer team on 0845 608 8866.
Paul Wilson, commercial accounts director, Pfizer

Rx switches

I was wondering if any of your readers have had a similar problem to myself, whereby the PPA incorrectly scanned exempt scripts as chargeable ones, despite the backs being filled in correctly.

The PPA admitted it was responsible for placing them in the wrong pile, which resulted in 80 forms being incorrectly scanned. This took quite a bit of time to sort out but eventually resulted in a refund of £568.

I am somewhat nervous as to how often this could be happening – for example if the number switched had been just a couple every month instead of 80, it may have been quite difficult to spot.

Both the PPA and PSNC say the process is constantly audited but they did not know why it had occurred – an unsatisfactory answer.
Kieran Eason, manager, Easons Pharmacy, Wilnecote, Staffs

Consultation correction

The consultation on the draft Pharmacy Order 2009 (http://tinyurl.com/3ptfqt), which sets out proposals to create a new pharmacy regulator, is being conducted by the DH and not the RPSGB as stated in C+D, January 31, p18, 'Letter of the Law'.

Are you logging nine CPD records a year?

From March 1 you will have to...

To give your patients the maximum benefit of your expertise, you need to continually update your knowledge. In addition, as mandatory CPD for practising pharmacists draws closer, it's time to think about your continuing education for 2009.

Why not register with the leading weekly magazine for pharmacists?

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Don't forget – from March 1 CPD becomes mandatory!

See page12 for more information

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C+D Clinical

Reporting ADRs – why bother?

The first in a series on how to spot adverse drug reactions concentrates on the importance of reporting

60-second summary

Why must ADRs be taken seriously?
The Yellow Card Scheme suffers from severe under-reporting. Doctors may even tell patients to put up with a side effect or that it's all in the mind. If this attitude prevails, not only will nothing further be learned about ADRs but patients' confidence in health professionals and medicines may be undermined.

What does SCOOTA stand for?
It's a reminder of questions to ask when deciding if symptoms could be an ADR – Symptoms/severity, Cause, Outcomes, Other causes, Timing, Actions (see Box 2).

Did you know that 70 per cent of ADRs are preventable?
MURs are valuable in this respect because you can check doses and suitability of medicines.

Reflect

How would you define pharmacovigilance? What are type A adverse drug reactions? Who can report an ADR through the Yellow Card Scheme? What are black triangle drugs?

Plan

This article discusses the importance of reporting ADRs and the Yellow Card Scheme. It contains advice on how to question people who report symptoms that might be ADRs, and how to encourage patients to report them.

Professor Janet Krska

Mrs GB, one of your regular customers, describes leg pains, a recent problem causing difficulty walking. Her PMR shows she started on atorvastatin two months ago. Is this an ADR and what should you do?

Muscular pain or myalgia is a 'common' ADR with atorvastatin, occurring in between 1 and 10 per cent of patients. It is dose-related and caused by all drugs in this class, so may be a type A effect.

Atorvastatin is highly likely to be causing Mrs GB's myalgia, but your advice depends on her replies to questioning. Pharmacists have a duty to report serious ADRs and are asked to help patients report directly. Although Mrs GB's symptom is well known, she could report it via the Yellow Card Scheme. You should record it on your PMR.

Medicines can all cause adverse reactions, which may manifest as symptoms, which often make patients want to stop the medicine, or as unseen effects including biochemical abnormalities. The World Health Organization defines these adverse drug reactions (ADRs) as in Box 1 (overleaf).

There are two main types of ADR: type A reactions are most common and, because they are predictable, are often preventable; type B reactions are more likely to be serious and to cause death.

The Yellow Card Scheme is the main system for monitoring the safety of medicines in the UK

Pharmacovigilance schemes

The main system for monitoring the safety of medicinal products in the UK is the Yellow Card Scheme (YCS), run by the Medicines and Healthcare products Regulatory Agency (MHRA). Pharmacists can submit yellow cards, and the general public has been able to report directly since 2005. Statins have so far generated the largest number of patient reports.[1]

The scheme suffers from severe under-reporting because of various factors, including lack of certainty that the medicine caused the symptom, guilt feelings, fear of reprisal and apathy. YCS data cannot provide the incidence of any individual ADR from any drug, partly because of under-reporting, but also because the number of patients prescribed a particular drug is not known.

Prescription event monitoring (PEM), managed by the Drug Safety Research Unit at Southampton University, involves only some GPs but can estimate the incidence of ADRs by prospectively following up all patients prescribed a given drug over a given period. Only some drugs are studied, so the scheme complements YCS data.

Incidence of ADRs

ADRs are responsible for about 6.5 per cent of hospital admissions to general medical wards[2] and up to 14 per cent to care of the elderly wards.[3] During a hospital stay, 15

CPD

This article (Module 1464) can help in the following CPD competencies: **G1a, G1d, G1e, G1f, C1b, C1c, C1j.** See http://tinyurl.com/68ox7b

BOX 1: DEFINITIONS

Adverse drug reaction: "Any response to a drug which is noxious and unintended and which occurs at doses used for prophylaxis, diagnosis or therapy of disease, or for modification of physiological function" (WHO).
Type A reaction: Predictable normal or augmented responses caused by pharmacological effects, which are dose-dependent.
Type B reaction: Unpredictable (bizarre) reactions unrelated to the drug's pharmacology or to dose.
Pharmacovigilance: "The science and activities relating to the detection, assessment, understanding and prevention of adverse effects or any other drug-related problem" (WHO).
Causality: A necessary relationship between one event (drug) and another (adverse reaction), where the second is the direct result of the first. May be: definite, probable, possible, unlikely, unclassifiable.
Signal: Reported information on a possible causal relationship between an adverse event and a drug, the relationship being unknown or incompletely documented previously.

per cent of patients may experience an ADR.[4] There is less information about the incidence of ADRs in the community, but studies suggest that between 30 and 40 per cent of people experience symptoms they perceive to be ADRs from prescribed medicines.[5,6] Even less is known about ADRs to OTC products.

Attitudes to patient reporting

For the YCS to identify important problems, experiences reported by patients or their representatives must be taken seriously by health professionals, who can report ADRs or advise patients to do so. Many patients in one UK study had reported suspected ADRs to their GP, but few of these had been recorded and even fewer reported via the YCS. A US study described some responses from GPs when faced with side effects from statins.[7] Patients were dismissed with remarks such as: "suggested it was my imagination"; told to put up with it: "protecting the heart more important"; and even told that the statin could not be responsible – "not the cause of body aches".

If these attitudes prevail, not only will nothing be learned about potential ADRs, but patients' confidence in health professionals and medicines may be impaired. So it is essential to treat any experiences reported to you seriously.

Questioning people reporting ADRs (see Box 2)

Symptoms/severity: Try to obtain a full description of symptoms and their impact on the patient. Can they be tolerated as an acceptable, albeit unwanted, effect traded off against the medicine's benefit? Are they mild or unpleasant, but not affecting everyday activities, or more severe? Symptom severity also influences whether a report should be made through the YCS.
Cause: Find out all relevant details of the medicine suspected of causing the symptoms: drug, brand, dose, dosing frequency and treatment duration. Brand changes can precipitate ADRs, since excipients as well as active ingredient can be responsible. Some reactions are dose-related, others are cumulative.
Outcomes: Ask if symptoms are still current, so you can provide the best advice. If still present, you may need to advise on treatment, refer elsewhere or advise on stopping or continuing the medicine.
Other causes: Often new symptoms can be explained by examining other concomitant medicines or medical conditions. Initiating a new medicine may precipitate an ADR due to an interaction. Two or more medicines with similar side effects can increase the chances of the side effect becoming apparent. Knowledge of previous allergies can help to inform judgements about the likelihood of the medicine or its excipients being the cause.
Timing: For a symptom to be considered an ADR, it should either not have been present at all before the medicine was taken, or should have got worse after taking the medicine. Most ADRs appear within hours or days of starting a medicine, but some can take weeks, months or even years to become apparent. Symptoms may change in line with dosing, which increases the degree of certainty about the association.
Actions: Most importantly, is the suspect medicine still being taken or has it been stopped or the dose changed? Has the patient information leaflet been consulted? It lists many side effects usually derived from clinical trials. You may wish to look at the PIL with the patient, to find out if the symptom is listed. You also need to know if the reporting patient has informed anyone else, such as the GP, or made a report through the YCS.

Assessing causality

Many different methods have been devised to help decide whether an individual symptom is caused by a particular drug. Most use five factors in making the judgement:

- a temporal relationship between administration and onset of effect
- the effect disappears or reduces when drug is stopped or dose reduced
- the effect reappears when drug is reintroduced
- the effect has been previously reported to this drug or to similar drugs
- the effect cannot be attributed to other

concomitant drugs or diseases.

Most people are unlikely to restart a medicine they believe to have caused an ADR. Also, multiple medicines and pathologies are common, making it difficult to judge whether any particular symptom was caused by a given drug. Remember it is not necessary to be certain about causality to make reporting through the YCS useful. The scheme detects signals (see Box 1), which are generated from the numbers of reports submitted. If more reports are submitted, signals can be detected earlier and with greater certainty.

Identifying potential ADRs

Community pharmacists have many opportunities to identify potential ADRs. People may present with symptoms they believe to be an ADR or seek advice on treating new symptoms. When you ask about medicines being taken, in response to such requests, consider whether they could be causing the presenting symptom. Pharmacists can gather information about side effects during MUR consultations or when dispensing repeat prescriptions. Prompting about common side effects doesn't increase the frequency with which patients report them. Most importantly, taking relevant action will ensure good outcomes for the sufferer and contribute to pharmacovigilance.

BOX 2: SCOOTA

General questions to ask people reporting a suspected ADR about:
Symptoms/severity: What exactly were the symptoms experienced and how severe are/were they?
Cause: What medicine do they suspect caused the symptoms?
Outcomes: Have the symptoms gone away, reduced or still causing problems?
Other causes: Could other medicines being taken, medical conditions or allergies explain the symptoms?
Timing: When did the symptoms start in relation to taking the medicine?
Actions: What actions have already been taken?

Preventing ADRs

Over 70 per cent of ADRs are preventable. When doing an MUR, try to ensure that medicines are appropriate for individual patients, recommended dosages are not exceeded and any recommended monitoring has been done. Ask about ADRs/allergies and record them on your PMR. Checking that all medicines are needed is valuable, because it can help to reduce unnecessary medicines and thus help to reduce future ADRs due to interaction or duplication of effects. Any information you have on renal and liver function can be useful in advising about reducing doses or avoiding certain drugs.

Explaining ADR risk

The EU-recommended terms used in PILs equate to ADR frequency and range from more than 10 per cent, which is termed 'very common', to less than 0.01 per cent or 'very rare'. Explaining 10 per cent as one in every 10 people and 0.01 per cent as up to one in 10,000 people may help patients to understand them more easily.

Your role in ADR reporting

Pharmacists should report, and encourage the public to report, as often as possible. The quickest way is directly to the MHRA via www.yellowcard.gov.uk. Paper forms can be found in the BNF or downloaded from www.mhra.gov.uk.

- Always consider an ADR when any new symptom is presented – ask about medicines or other products being taken. Be extra vigilant in people at higher risk of ADRs, such as the elderly, children and those taking multiple medicines.
- Record previous ADRs on PMRs to make sure they don't recur.
- When initiating new medicines, explain the risks of ADRs in terms patients can understand.
- When patients suspect an ADR, treat ▶

them seriously. Even if you assess the suggested link as unlikely, the experience may impair their confidence in the medicine, which will need your intervention.
• Always report any suspected ADR with black triangle drugs, non-prescription drugs and herbal products, plus serious ADRs with other drugs.
• Encourage patients to report any symptom not listed in the PIL and any interference with everyday activities.

Further articles in this series will discuss whether common symptoms seen in a community pharmacy are likely to be drug- or disease-related, and advise on what actions to take and when to report.

Janet Krska is Professor of Pharmacy Practice, School of Pharmacy and Biomolecular Sciences, Liverpool John Moores University.

Further reading and references are online at www.chemistanddruggist.co.uk/update

Your Continuing Professional Development

CPD

Act

• Read more about the Yellow Card System from the Medicines and Healthcare products Regulatory Agency (MHRA) at http://yellowcard.mhra.gov.uk. Read and print out the downloadable information leaflets on Guidance to Reporting if you think they may be useful.
• More advice on what to report can be found on the MHRA website at http://tinyurl.com/7dbubx including areas of special interest, a list of serious reactions, what information to include and causality.
• Revise your knowledge of black triangle drugs. The MHRA website has an up to date list at http://tinyurl.com/4t5rv5.
• Find out more about the prescription event monitoring system mentioned on the Drug Safety Research Unit website at http://www.dsru.org/pem2002.html.
• For further learning, the CPPE has a programme on Adverse Drug Reactions (ref 34678) available at www.cppe.ac.uk or by calling 0161 778 4024.
• Have you ever spotted an ADR? How could you be more vigilant? Think how you could encourage your patients to report ADRs and how you could raise their awareness of the Yellow Card System. Make a note of the next ADR you come across.

Evaluate

• Do you now have a sound knowledge of the Yellow Card System and how and what to report when an ADR occurs? Could you use this information to spot ADRs and encourage your patients to report them?

A Practical Approach — Once-daily doses

David Spencer, pharmacist at the Update Pharmacy, has been allowing his pre-registration trainee Joanna, who has completed a six-month placement in a hospital, to do some MURs under his supervision.

After several sessions, David says to Joanna: "I've noticed you've been giving some interesting advice to patients about timing of drugs they take once daily."

"Yes," Joanna replies. "I did a project on chronotherapeutics in my hospital placement, and all the advice I gave is evidence-based."

"In that case," David says, "you ought to share your knowledge with the GP practice I give prescribing advice to. At our next meeting, I'd like you to give a presentation

on the timing of doses of antihypertensive drugs taken once daily. I'd like you to cover diuretics, calcium channel blockers, ACE inhibitors, angiotensin II receptor antagonists and doxazosin. And you should back up your advice with relevant references."

"I think I could do that," says Joanna.

Questions

1. What is the most important underlying factor in relation to timing of once-daily drugs for hypertension?
2. What are the main points of Joanna's presentation in relation to the above drugs?

Can you suggest a scenario for Practical Approach? We're offering a £10 Amazon voucher for those we publish. Email ideas to haveyoursay@cmpmedica.com

Answers

1. Blood pressure is subject to circadian biorhythms and fluctuates over 24 hours, being higher during the day than at night. A 10 per cent or greater decrease in blood pressure during sleep is considered normal. Individuals whose BP falls by this amount are classified as 'dippers'. The rest, who comprise 10 to 40 per cent of the population, are 'non-dippers'[1,2]. It is thought that the overall mean blood pressure determines the risk of future cardiovascular damage and that 'non-dippers' are at higher risk. A growing body of evidence suggests that more advanced target-organ damage and worsened prognosis occurs in patients with blunted nocturnal reduction in BP.

2. **Diuretics:** Indapamide and bendroflumethiazide should be given in the morning, as urinary Na/K ratio is increased significantly and side effects are lower. However, the efficacy of torasemide is significantly higher with bedtime dosing, and full 24-hour therapeutic coverage occurs only when torasemide is given before bedtime.[3]

CCBs: Nifedipine (Adalat LA): bedtime administration greatly reduces incidence of oedema and all ADRs, when compared with morning dosing.[4,5] Amlodipine: optimal dosing time to reduce 24-hour and night-time BP may be morning.[6] Nisoldipine: morning.[7] Verapamil m/r: at bedtime to achieve maximum plasma concentration in the early morning and extended release over 24 hours.[8] Diltiazem: bedtime dosing provides enhanced 24-hour control and optimal morning protection, when patients are at greatest risk.[9]

ACE inhibitors: Generally, bedtime, for reduction of both BP and, with enalapril, for dry cough ADR10-16.

ARBs: No single optimal dose time for all drugs in this group has been established. No difference between morning or evening has been found for several, while for others it was either morning or evening.[17-23]

Doxazosin Morning dosing has been found not to provide full 24-hour BP lowering while bedtime dosing did.[24] However, dosing time did not appear to influence the efficacy of doxazosin for benign prostatic hyperplasia.[25] For references and further reading, go to www.chemistanddruggist.co.uk

This article can help in the following CPD competencies: **G1, G1b, G1c, G1d, G6f, G8g, C1a, C3e, C4c**
See http://tinyurl.com/68ox7b

New

Avamys®

fluticasone furoate

Nasal and **ocular** symptom relief

Welcome to a world of **allergic rhinitis relief...**

Avamys is a new intranasal steroid providing relief from both nasal and ocular seasonal allergic rhinitis and its symptoms.

It's a once daily therapy[4] available in an award winning device.[5]

Prescribing Information

(Please refer to the full Summary of Product Characteristics before prescribing)

Avamys® ▼ **Nasal Spray Suspension (fluticasone furoate 27.5 micrograms /metered spray) Uses:** Treatment of symptoms of allergic rhinitis in adults and children aged 6 years and over. **Dosage and Administration:** For intranasal use only. *Adults:* Two sprays per nostril once daily (total daily dose, 110 micrograms). Once symptoms controlled, use maintenance dose of one spray per nostril once daily (total daily dose, 55 micrograms). *Children aged 6 to 11 years:* One spray per nostril once daily (total daily dose, 55 micrograms). If patient is not adequately responding, increase daily dose to 110 micrograms (two sprays per nostril, once daily) and reduce back down to 55 microgram daily dose once control is achieved. **Contraindication:** Hypersensitivity to active ingredients or excipients. **Side Effects:** *Common:* nasal ulceration. *Very common:* epistaxis. Epistaxis was generally mild to moderate, with incidences in adults and adolescents higher in longer-term use (more than 6 weeks). **Precautions:** Systemic effects of nasal corticosteroids may occur, particularly when prescribed at high doses for prolonged periods. Treatment with higher than recommended doses may result in clinically significant adrenal suppression. Consider additional systemic corticosteroid cover during periods of stress or elective surgery. Caution when prescribing concurrently with other corticosteroids. Growth retardation has been reported in children receiving some nasal corticosteroids at licensed doses. Monitor height of children. Reduce to lowest dose at which effective control of symptoms is maintained or refer to paediatric specialist. May cause irritation of the nasal mucosa. Caution when treating patients with severe liver disease, systemic exposure likely to be increased. **Pregnancy and Lactation:** No adequate data available. Recommended nasal doses result in minimal systemic exposure. It is unknown if fluticasone furoate nasal spray is excreted in breast milk. Only use if the expected benefits to the mother outweigh the possible risks to the child. **Drug interactions:** Caution is recommended when co-administering with inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole and ritonavir. **Presentation and Basic NHS cost:** Avamys Nasal Spray Suspension: 120 sprays: £6.44 **Market Authorisation number:** EU/1/07/434/003 **Legal category:** POM. **PL holder:** Glaxo Group Ltd. Greenford, Middlesex, UB6 0NN, United Kingdom. **Last date of revision:** December 2008

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to GlaxoSmithKline on 0800 221 441.

References:

1. Fokkens WJ, Jogi R, Reinartz S *et al.* Once daily fluticasone furoate nasal spray is effective in seasonal allergic rhinitis caused by grass pollen. *Allergy* 2007; **62** 1078-1084.
2. Kaiser HB, Naclerio RM, Given J *et al.* Fluticasone furoate nasal spray: a single treatment option for the symptoms of seasonal allergic rhinitis. *J Allergy Clin Immunol* 2007; **119**(6): 1430-1437.
3. Ratner P, Andrews C, van Bavel J *et al.* Once-daily fluticasone furoate* nasal spray (FF) effectively treats ocular symptoms of seasonal allergic rhinitis (SAR) caused by mountain cedar pollen.*USAN approved name. *J Allergy Clin Immunol* 2007 **119**(Supp 1): S231.
4. Avamys Summary of Product Characteristics.
5. Medical Design Excellence Awards 2008 winner. www.mdeawards.com Accessed on 9/12/08. Medical Design Excellence Award 2008 winner. The award is based upon descriptive materials submitted to the jurors: the jurors and the competition operators did not verify the accuracy of any submission or of any claims made and did not test the item to which the award was given. For further information please visit www.mdeawards.com

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ALLEN & HANBURYS

GlaxoSmithKline
Freephone 0800 221441
Fax 020 8990 4328
customercontactuk@gsk.com

GlaxoSmithKline

Clinical Alerts

SPC changes

Exjade 125 mg, 250mg, 500mg dispersible tablets (deferasirox) Concomitant treatment with rifampicin, carbamazepine, phenytoin, phenobarbital or ritonavir may reduce efficacy. Novartis Pharmaceuticals UK, 01276 698370, medicalinfo.phgbfr@novartis.com

Mirena (levonorgestrel) Now includes instruction for the healthcare professional to check that the Mirena is intact following removal. Bayer, 01635 563000

Combigan (brimonidine, timolol maleate) Extensive revisions including removal of undesirable effect hypotension and new information on pregnancy and lactation. Allergan, 01628 494026, uk_medInfo@allergan.com

Voltarol Ophtha Multidose 0.1 per cent eye drops (diclofenac) New information on need for caution when used with topical steroids in patients with significant pre-existing corneal inflammation. Novartis Pharmaceuticals UK, 01276 698370, medicalinfo.phgbfr@novartis.com

Lamisil 250mg (terbinafine) Pancytopenia added as a side effect with unknown frequency. Novartis Pharmaceuticals UK, 01276 698370, medicalinfo.phgbfr@novartis.com

New Products

Stelara (ustekinumab) For adults with moderate to severe plaque psoriasis who have failed to respond to other systemic therapies, or are prevented from taking them. Janssen-Cilag, 0800 731 8450, medinfo@janssen-cilag.co.uk

Supply Issues

Singulair 4mg paediatric granules (montelukast) There is a temporary shortage of this product, which should be resolved by April 2009. Chewable Singulair tablets may be used as an alternative. MSD, 01992 467272

Effentora is approved

Scottish Medicines Consortium members have approved fentanyl buccal tablets (Effentora) for restricted use in treating cancer breakthrough pain in patients in whom other short-acting opioids are unsuitable.

The pain relief treatment was approved because it showed improvement in pain relief compared to placebo, and because the tablets are convenient to use and no more expensive than an alternative given as a lozenge.

The organisation did not approve the etonogestrel/ethinylestradiol vaginal ring (NuvaRing). It found that device-related problems and vaginitis were more common in patients using the treatment, and that while it was more expensive than existing contraceptives, there was no evidence it was more effective.

Complementary medicines largely ineffective, says arthritis charity

Most complementary treatments used in rheumatoid arthritis, osteoarthritis and fibromyalgia are not supported by evidence, experts have concluded.

A report by Arthritis Research Campaign (ARC) researchers has shown evidence from randomised controlled trials is available for only a fraction of alternative and complementary treatments, and the available data suggests as many as two-thirds of treatments sold for RA are not effective.

It also calls into question the effectiveness of popular glucosamine supplements, as measured by improvements in pain, movement or general wellbeing.

One treatment identified by the ARC as being helpful in RA is fish body oil, while capsaicin gel was helpful in osteoarthritis.

In RA, antler velvet, blackcurrant seed oil, collagen, eazmov herbal preparation, feverfew, flaxseed oil, green-lipped mussels; homeopathy, reumalex herbal mixture, selenium, Chinese herb tong luo kai bi, antioxidant vitamins and willow bark were shown to have little or no effect.

ARC medical director Professor Alan Silman said natural medicines were widely used by people seeking to avoid conventional drugs, which they viewed as potentially harmful. "However, natural does not mean they are either safe or effective."

Complementary and Alternative Medicines for the Treatment of Rheumatoid Arthritis, Osteoarthritis and Fibromyalgia is available from the ARC. www.arc.org.uk

Want to know more about coeliac disease? Go to www.chemistanddruggist.co.uk/clinicalindex

Steroid nasal inhaler improved

GlaxoSmithKline has launched a nasal steroid spray for seasonal allergic rhinitis in a novel inhaler device said to reduce the problem of the treatment dripping down the back of the patient's nose.

It is indicated for treating symptoms of allergic rhinitis in patients from 12 years with a starting dose of two sprays per nostril once daily, and a maintenance dose of one spray per nostril per day.

The new device delivers a scent-free mist with a low volume of spray, which means patients are not left with a bitter taste or drip down the back of the throat. Avamys: Pip code: 343-8587; Price: £6.44 for 120 doses.

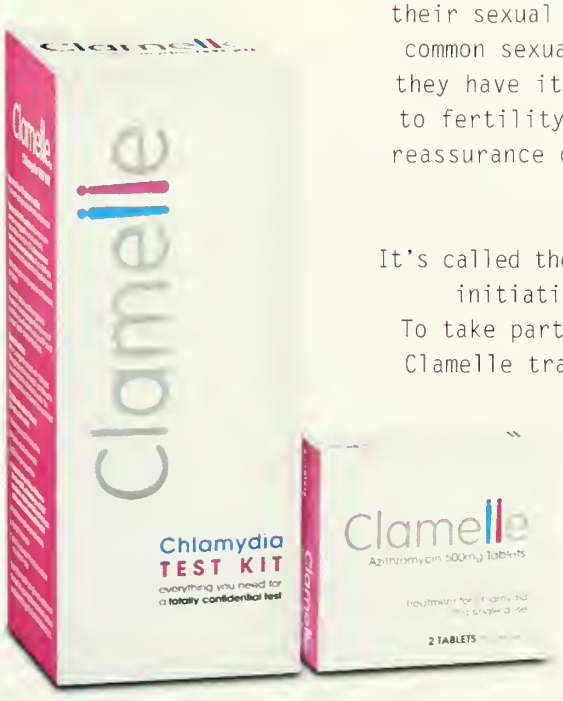
Child drug testing needed

The general public are not aware that many medicines used in treating children are not licensed for the purpose, a survey by Queen's University Belfast researchers has revealed.

The survey found that 86 per cent had never heard or read about the issue. Research leader Professor James McElnay said the lack of medicines tested in children was putting them at a disadvantage.

£2m CONSUMER CAMPAIGN COMING SOON

THE MOTHER (AND FATHER) OF ALL POM-TO-P SWITCHES.



It is now possible to treat people with confirmed chlamydia and their sexual partners without a prescription. Chlamydia is the most common sexually transmitted infection. People generally don't know they have it, but left untreated chlamydia poses a serious threat to fertility. Now you can offer potential mothers and fathers the reassurance of a diagnostic test and - *for the first time without prescription* - an oral antibiotic to clear the infection.

It's called the Clamelle chlamydia service, a significant public health initiative made possible by the POM-to-P switch of azithromycin. To take part you will need to register with the NPA, complete your Clamelle training and order Clamelle. Then you'll be ready to help your customers on their way to parenthood.

To register with the NPA, contact 01727 800 401.

Clamelle®
Azithromycin 500mg Tablets

The first OTC oral antibiotic is here to treat chlamydia.

New duo from Pharma Nord

Pharma Nord has added two products to its VMS offering.

D-Pearls contain vitamin D_3 (cholecalciferol) with each capsule providing 20mg. The fat-soluble vitamin plays an important role in maintaining blood levels of calcium, and supporting healthy muscles and nerves, says the company. While the body is able to produce vitamin D when exposed to sunlight, supplementation may be necessary during the short days of winter and for people who do not expose their skin to the sun.

The second newcomer is Bio-Glucan. Derived from baker's yeast, each capsule provides 200mg beta 1-3, 1-6 glucans and could support natural defences against allergies and infection, says Pharma Nord. It is particularly recommended for those with a weakened immune system, due to lifestyle, stress or ageing.

Both products are being supported with PR activity and coverage in consumer and trade publications. An introductory offer of 'six plus one' for D-Pearls is available to the trade or '12 plus two' for repeat orders.

For nutritional advice on the products, contact Gareth Zeal at advice@pharmanord.co.uk or phone 07970 543117.

Prices: D-Pearls £5.95/120; Bio-Glucan £17.45/50, £34.90/125
Pharma Nord
Tel: 0800 591756
uksales@pharmanord.co.uk

Vagisil's fresh TV run

Feminine care range Vagisil is set to benefit from promotional support in the shape of a national television advertising campaign. Running for four weeks, the advertising is part of a £1 million investment in the brand this year.

The range includes a medicated crème to relieve external itching and irritation, feminine wash, wipes, powder and deodorising mist.

Product info:
Combe International
Tel: 0208 680 2711

Care to step this way?

Lesley Ribbens

Thornton & Ross is taking its Care brand into new territory with the launch of the Advanced Gel Footcare range.

The eight-strong range relieves foot discomfort and the products' slim-line design means they will fit comfortably in most shoes, says Thornton & Ross.

The gels contain a blend of minerals and vitamin E to moisturise the skin and help reduce friction and irritation. Packs can be merchandised on shelf or displayed on euro hooks.

The range comprises Advanced Gel toe protector, toe support, toe spreader, toe separators, corn protectors, bunion relief sleeve, bunion guard and metatarsal pads, with recommended prices starting at £2.75.

There is expected to be high demand for the products among the over-50 age group.

Thornton & Ross is supporting the launch with pharmacy training materials to aid correct recommendation and with consumer promotions in magazines and websites.

FREE! We have complete sets of the range to give away to three C+D readers. Email your name and address to competitions@cmpmedica.com with 'Care advanced gel footcare' as the subject by February 27

Prices and Pip codes:
see C+D Monthly Pricelist or visit www.cddata.co.uk
Thornton & Ross
Tel: 01484 848200

Don't mist out

Optrex ActiMist Eye Spray is to star in its own TV ad campaign from this month, with supporting media in the consumer press.

A clinically proven, contact lens friendly treatment for dry eyes, Optrex ActiMist contains liposomes that, when sprayed onto the closed eyelid, transfer to the edges of the inner eyelids and mix with the eye's natural lipids to relieve dry eyes.

It comes as a 10ml spray containing 100 metered doses and due to the sterile spray delivery system has a shelf life of three years. Full training guides are available for pharmacy staff at the Optrex website.

Product info:
Reckitt Benckiser, tel: 01482 326151, www.cddata.co.uk
www.optrex.co.uk

Roll up to Select better baking

A new recipe has been developed for Glutafin's gluten-free Select part-baked white rolls. The result is softer, tastier and lighter bread, says the company.

For best results, they should be baked in the oven to give a crispy crust but they can be eaten straight from the pack.

The rolls are low in fat and high in fibre. They are available on prescription to qualifying patients or can be bought OTC.

Pack size: 4
Pip code: 344-2753
Glutafin Ltd
Tel: 0800 988 2470
glutenfree@glutafin.co.uk

Eradicil winners

The winners in the recent Eradicil C+D reader giveaway are: M Pabari, Dr Chris Jordan, Dineshkumar Oswal, Kulbir Badyal, Gilda Azema, Mrs P Newton, Vipul Dodhia, Latta Parmar, Vincent Watts, Vicky Ayling, Chandresh Patel and Dr Anne Lewis. Congratulations! For more chances to win, look out for giveaways on C+D's product pages and online at www.chemistanddruggist.co.uk/prodnews

For on TV this week see www.chemistanddruggist.co.uk/prodnews

Bus route

A nationwide ad campaign for Kilkof cough medicine is underway, says manufacturer Bell's. The first phase sees the brand advertised on the back of buses throughout the north west with a 'No bull' message. Print ads and PR activity will support in the popular press and daily papers this year and into 2010.

Bell's; tel: 0151 422 1200

Natural cleansing

Faith in Nature has stepped into the feminine cleansing market with the launch of two products for daily use.

The Feminine Wash contains organic aloe vera and essential oils. It is designed to cleanse and refresh even the most sensitive skin, says Faith in Nature, and has a natural odour control mechanism and is hypoallergenic.

The second newcomer, Feminine Wipe, is positioned for on-the-go use. Free from synthetic chemicals, the 100 per cent viscose wipes are flushable and biodegradable.

Both products carry the logos of the British Union of Anti-Vivisection and the Vegan Society.

Prices: wash £3.99/200ml; wipes £2.49/15
Faith Product Ltd
Tel: 0161 724 4016

What you need to know about...

...self-harm

Self-harm is a favourite topic for teen soaps, but what do you really know about it? And would you know what to do if you suspected it? **Caroline Roe**, director of patient support organisation Harmless, offers insight and advice

First and foremost, self-harm is a coping strategy. Regardless of the feelings that drive it, and the events that have led to self-harm, it is a means of survival. Self-harm is not attempted suicide, its motive is not about ending life but about sustaining it and managing the feelings the person is experiencing.

Self-harm is most common in children over the age of 11, increases in frequency with age and is more common in girls than boys. A 2002 study of 15 to 16-year-old schoolchildren found 11 per cent of girls and 3 per cent of boys said they had harmed themselves in the previous year.

What is self-harm?

Self-harm can take many forms. Often we hear stories about people who cut themselves, but it is so much more than cutting. People may take overdoses or burn themselves, scratch or hit themselves, pull their hair out or insert objects under their skin. The method of harm is not indicative of the level of distress, nor should we categorise people in that way. If someone cuts themselves superficially, their emotional pain is no less valid than someone who takes an overdose or needs stitches.

What causes it?

People often turn to self-harm at a time of difficulty in their life, but what is distressing for one individual may not be for another. There are common experiences that people report as contributors to their self-harm, including bereavement, relationship difficulties, body

image, abuse and trauma, school and work pressures. Anything that could cause an increase in stress or distress may indeed cause someone to self-harm, and this can happen at any age; however, for some individuals there may not be any trigger event. Self-harm may occur from a period of stress, depression, or anxiety, or low self-worth.

Why do people self-harm?

Self-harm helps people in that it gives them some respite from their emotional discomfort. This might be described as a release, but it can also be a way of expressing on the outside what is going on, on the inside.

People may also self-harm because they hate and want to punish themselves. For many who self-harm, there may be a variety of methods used at different times and for different emotional states. Some of the reasons people give for harming themselves include getting a sense of control, to release or discharge emotional tension, or simply because they do not know what else to do. People who self-harm often feel very desperate, but find self-harming can help alleviate the level of distress and enable them to continue with life.

What are the consequences?

Although self-harm can help people manage on a day-to-day basis, it can create its own problems. Many people who self-harm feel ashamed of how they cope, and this reluctance to talk about their difficulties can perpetuate things further. Isolation and feeling misunderstood can lead to the feelings of despair that drive self-harm. Further to this, it can leave lasting physical damage, and scarring can be a major cause for concern among people who have self-harmed at some point in their lives. While some people value the journey they have travelled and scars are a part of that, for others scarring can be a continual reminder of the distress they have experienced. Scars communicate to the world what most people who self-harm would like to keep private.

What role does pharmacy play?

If we start to consider the physical injuries people might cause themselves, and the extreme difficulty individuals face in accessing support or healthcare, it is extremely important to consider the role of the pharmacy in the lives of people who self-harm. For many individuals who self-harm, purchasing dressings from the local pharmacy may be the only contact with a service they have. Increasingly, GPs may consider encouraging self-management and woundcare by prescribing burn dressings, or Steristrips on prescription as a treatment option.

> "It is important to remember that self-harm is not the problem – it is the symptom"

It is also essential to consider that people who self-harm may not just buy items to care for their self-harm, they may also purchase the instruments for their self-harm including blades, and substances to overdose or self poison with. This places the pharmacy in a position of responsibility, and it is absolutely essential we start to have a dialogue about self-harm with pharmacists and pharmacy assistants.

What can be done to help?

It is important that each individual gets the help and support they need and is right for them. Different people need different things, depending upon the feelings that have led to the self-harm in the first place. It is essential that individuals are given the opportunity to deal with the painful feelings or experiences that drive the self-harm; without this, the self-harm will persist.

It is important to remember self-harm is not the problem – it is the symptom of other difficulties. Individuals who self-harm may find they need therapy or counselling to help them through their difficulties, however some may find the support from friends and family to be enough. What we do know is that compassionate contact with any other individual can have a massive impact on the recovery or sense of hope an individual feels; this can help people to have a sense of faith that others in the future will be able to help them. Staff within a pharmacy may be able to create that safe and compassionate space for the individual.

What you can do

Self-harm leaves many of us feeling frightened or helpless, but if we are able to set this aside for the good of the individual, we may be able to support the person appropriately. Simple things staff can do include enquiring whether the individual needs any support, or being able to respond or listen if a person discloses self-harm.

It may be that an individual tells you they have harmed themselves, and it is essential to remain calm and not show shock and pity, but care and compassion. Try to remember how desperate the person is feeling and, if possible, create a bit of space and time for them. Try to avoid direct questions, but subtle measures such as having information on hand that can be included with purchases, or is accessible on the premises, may help the individual seek help if they require it.

All too often we place so much pressure on ourselves to say the right thing, but it is important to remember that sometimes we can say the wrong thing in the right way. If the individual is met with compassion and kindness, this can have a huge therapeutic impact.

Case Study

Sarah started to self-harm when she was in her teens, and continued into her 20s. Following struggles with her identity, difficulties at home and a reduced ability to talk to people about how she was feeling, the self-harm became more of a problem. She cut and burned herself on her hands and forearms. For Sarah, self-harm was the only way of expressing the absolute despair that she felt with herself and her life.

She frequently required medical intervention to treat the self-harm from her GP and the hospital. Sarah felt completely isolated and accessing medical treatment left her feeling afraid, often judged, and ashamed. If at all possible, she would try and self-care for her own wounds, and purchase dressings several times throughout the week from the pharmacy. Her wounds on her hands and forearms were visible sometimes; she hated her scars and felt ugly.

For more information

Pharmacy staff and pharmacists can access more support and information, as well as resources (leaflets and posters) from www.harmless.org.uk. Harmless provides support to professionals if they have any specific questions about how to support someone who they suspect is self-harming.
info@harmless.org.uk

How I set up a PBC COPD service

Get your head round practice-based commissioning and you'd be surprised what you can achieve. Community pharmacist Adam Crampsie reveals how he successfully pitched a COPD service to his local PBC

Imagine the scene: you are conducting a medicines use review with a patient on multiple inhalers and you start to check their technique: "Mrs Smith, could you show me how you use your blue inhaler?"

"Oh sonny, I'm an expert at this. I start by taking the cylinder out and rolling it on the table. Then I insert the inhaler to the back of my throat and squirt it 12 times, then breathe in very deep."

"Do you find that this works?"

"Not really but it's how I was told to do it."

If you have been conducting MURs on respiratory patients, I'm fairly sure this is not an unfamiliar narrative.

The concept behind the Community COPD Service came from experiences I gained through conducting MURs on patients with COPD. It quickly became clear that there was a wide spectrum of care given to patients with COPD, from those with excellent control of their condition, receiving optimum therapies, to those with very poor control on suboptimal medication.

A quick glance at the PMR of any patient with COPD will show you how tight a control is being achieved. How often do you find yourself dispensing antibiotics and steroids to the same patient, week after week? Exacerbations can be easily avoided through tight control of COPD by the use of optimal therapies and intensive management. It was from this idea that the Community COPD Service was born.

Around the time the service was conceived, the British Lung Foundation produced its Invisible Lives report. This stated that an estimated 2.8 million people in the UK have COPD without being aware. Armed with this knowledge, a robust pharmacy-based COPD screening service was designed and tagged onto the expanding Community COPD Service.

What is the Community COPD service?

The Community COPD Service is a pharmacist-led service conducting medication reviews on COPD patients. The service receives referrals from both primary and secondary care. If a patient has poor control of their symptoms, they are referred to the service by their GP or practice nurse. A full medication review is conducted along with spirometry.

Recommendations of medication changes are then made to the GP. Once these changes have been initiated, the patient is then managed intensively within the community by the service. Antibiotics and steroids are given to high risk patients and their exacerbations are self-managed with close support from the service. The main aim of the service is to reduce exacerbations that require hospitalisation. This increases the patient's quality of life and reduces spending by reducing admission rates.

No service can run without funding. Caring altruism gets you so far, but even in today's economic climate you can't purchase goods with kindness. Well, not legally! It was decided that an attempt would be made to secure funding from the local practice-based commissioning (PBC) cluster as COPD was one of its commissioning priorities.

The ever evolving National Health Service has an unhealthy obsession with acronyms. PCT, NRT, EPS, PMR, PALS... the list is seemingly endless. A new service is doomed from the start if it cannot make a snappy acronym. Many of us accept these terms, often adopting them into our everyday practice. There is, however, one acronym which offers both confusion and untapped potential for pharmacists: PBC.

Demystifying PBC

PBC is not a new concept. The term has been bandied around since the late 90s when a government white paper, The New NHS, stated that PCTs would extend commissioning budgets to GP practices to offer a wide range of services. It wasn't until April 2005 that these plans came to fruition.

Broadly speaking, PBC allows community clinicians to develop better services for their local communities. Pharmacists are in a prime position as community clinicians to start translating patient needs into new services offered in locations convenient to patients.

> The best service in the world will fall short if it does not address the priorities set out by the PCT

So began a long and steep learning curve. I had no experience, so quickly had to learn the procedures involved in commissioning a new service.

After a service design and specification was put together, a meeting was held with the PBC cluster head. The service was presented and was well received. At this point it seemed that everything was going to plan. Then came the first hurdle. Quite a monumental hurdle. The cluster made it very clear that they were interested in the service. They could see the great potential for savings through a reduction in unscheduled care and the positive benefits to the patients. However, due to the novel nature of the service, they were not willing to gamble funds, having no idea whether the service would prove successful.

We decided that a three-month pilot would be carried out with a select number of GP practices and that the intention to commission would be based upon the outcomes of the pilot.

The main problem with this was that the pilot would have to be unfunded. This meant no funding for equipment. For the service to run we needed a spirometer and a pulse oximeter and the consumables to be used alongside these.

Training was also needed. I started my respiratory diploma and attended courses on spirometry and COPD care. All of these costs were mounting up so I approached the major pharmaceutical companies that have a vested interest in respiratory disease. After selling the service to them I was able to secure grants to purchase equipment and to pay for training.

The pilot ran for the three-month period and the results were collated. I also used those three months to raise the profile of the service with anyone who would listen. I researched all the committees and groups that assess new business cases and met with all the key members to discuss the service. All along the way I had regular meetings with the PBC chair and the GPs involved to keep them on board. Once I had the data from the pilot, I set about having the service commissioned.

I took the results of the pilot to the commissioning group, who were pleased with the outcome. Based on the results, the decision was made to make the service one of their commissioning intentions for the coming financial year. Finance papers were drawn up and agreed and the crushing reality of the work to be done hit me like a sledgehammer!

The future

At the start of the financial year the service will be rolled out countywide and there will be a spirometer and a trained pharmacist in 20 pharmacies offering opportunistic screening of undiagnosed patients in the community.

To start a new service and have it commissioned is a difficult task but the experience gained from doing so is priceless. For a contractor to have a service commissioned it must target PCT/PBC priorities. The best service in the world will fall short if it does not address the key priorities set out by the PCT. Use local and national targets, pharmacy needs assessments and patient demand to assess what is needed at a local level.

Once a service design is in place, approach the PCT/PBC to find a source of funding. Use convincing arguments when in discussions, focus on the positive outcomes of providing the service, such as benefits to patient care and cost savings to the PCT for reinvestment.

The role of the community pharmacist is rapidly changing and practice-based commissioning offers an exciting opportunity to widen and advance your professional role.

Alan Crampsie is a community pharmacist in Durham

Have you successfully worked with PBC groups or are you yet to dip your toe in the water? Share your hopes and fears with C+D at **haveyoursay@cmpmedica.com**

Useful resources

www.improvement.nhs.uk
www.npa.co.uk
http://tinyurl.com/PBCresourcesforum
www.pcc.nhs.uk

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C+D AWARDS 09

Your turn in the spotlight

Championing the very best of community pharmacy, the C+D Awards 2009 celebrates the people and companies who go above and beyond the call of duty when delivering pharmacy services. Whether you are a newly qualified pharmacist or a pharmacy technician, an LPC chief executive or a pre-registration student, this is your chance to be in the spotlight. Tell us about your achievements and it could be you on the winner's podium.

Entry Deadline March 6

Enter online today
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Looking for a new job? Got a staff problem? C+D's new weekly careers section is your one-stop guide to making the right decisions

CAREER LADDER

My career choices

Co-operative Pharmacy managing director John Nuttall shares the wisdom gleaned from a quarter of a century in pharmacy

My big thing was, and always has been, cars, so when I was a little boy I wanted to be a racing driver. I actually had a go at it when I was about 17, but it didn't work out. I'm not sure I was good enough, to be honest.

My first experience of retail was working as a Saturday lad in a toy shop, but it was a summer placement in a steel factory that persuaded me further education of some sort was a good idea. I was quite interested in meteorology, but plumped for pharmacy because of its links to retail and business. I wouldn't profess to being very academic.

I did my pre-reg year with Boots, followed by a short spell as a relief manager with them. When I first started out I was very happy to be a coal face pharmacist, meeting the public. However, I didn't find pharmacy practice desperately fulfilling; this was in the 80s when the role was very different – pre-services, just running the dispensing operations and the store.

I moved to the former United Co-operative, as a pharmacist manager, as I felt I'd get much more progress with a smaller organisation. I started doing some work for head office, some buying for generics, then as the business grew I took various roles – head of professional services for 12 months, regional manager, operations manager, then general manager of the retail business. We then engineered a merger between the retail and wholesale elements and I was made MD – the rest is history.

The two Co-operative businesses merged in 2007 and I was made MD of healthcare and appointed to the executive board of the Co-operative Group. The business has grown from 18 stores to 800 and at each stage it's proved a new opportunity to influence a business that's changing and emerging. That's provided the stimulus for staying at one organisation.

There's no such thing as an average day but I'm not an early riser, so if I'm up and in the office by 8am that's pretty good. Today I was up at 6am and had a phone call with China at 7am. Then I was into our group meeting at 8am, followed by another phone call with China, a meeting over lunch, a few other phone calls and a quick meeting with finance. My chief executive is coming at 4pm for a meeting and I shall probably be here until about 6.30pm finishing off some board reports. Then I shall go home and have a glass of wine and read the paper.

The biggest motivator for me is the financial performance of the business. I'm really competitive so I like to be in a place where we're beating the competition. I do miss contact with the customers because you get immediate feedback and sometimes at this level you can't always see the immediate benefit of your input. I get frustrated when I'm not able to influence the big agenda as quickly as I would like; I'd like the pace of change in pharmacy to be quicker.

If this was the pinnacle of my career I wouldn't be disappointed. I do still think I've got value to add and I wouldn't rule out other opportunities, but it's not foremost in my mind.

Every year I make a life plan. I set out on a piece of paper what I want to achieve in the year and how that looks in five or six years, and then what I've got to do. I do it religiously; I put it in my diary and set aside half a day to complete it. I think that really helps have a sense of focus, so I've got a goal I'm working towards.

This year, we have got lots to do in the business, which I have got to get started on. On a personal level, I want to spend a bit more time with my children and on some property projects; getting the work-life balance right is important.

Honesty with yourself is really important. If you don't enjoy your job, then do something to change it. Most of us spend more time at work than we do at home so it's important to find a career that fulfils you and brings a sense of achievement.

CAREER TIP of the week

"Consider carefully which weaknesses you choose to reveal at interview. 'I don't have any' lacks conviction and lets slip that arrogance or dishonesty may be among your less pleasing qualities. Consider weaknesses that can be seen as training needs; areas that may require some development but which you have already begun to work on successfully; or weaknesses that can be made to sound like strengths, such as taking on too many projects"
Adapted from Brilliant Answers to Tough Interview Questions, by Susan Hodgson
www.chemistanddruggist.co.uk/booksforjobhunters

Alex Gourlay

At Alliance Boots...

Alliance Boots has announced two changes to its board of directors.

Boots UK MD Alex Gourlay has been appointed to the board and becomes chief executive of the health and beauty division.

Mr Gourlay joined Boots as a Saturday assistant over 30 years ago and, after qualifying as a pharmacist, worked his way up through the company via management positions in store operations and human resources.

Alliance Boots executive chairman Stefano Pessina said of the appointment: "Alex will quickly prove a real asset to the board, with his extensive knowledge of pharmacy-led health and beauty retailing."

And Alliance Boots wholesale and commercial affairs director Ornella Barra has been promoted to chief executive of its pharmaceutical wholesale division. Already a board member, she retains responsibility for commercial affairs.

Pharmacist Ms Barra was also recently appointed as a special professor at the University of Nottingham School of Pharmacy.

Mr Pessina added: "We have a strong and forward-thinking management which benefits from the wide experience of Ornella, Alex and health and beauty executive chairman Steve Duncan."

Do you have a career-related question for C+D?

Email jrichardson@cmpmedica.com and we'll ask the experts

Amanda Wells is reunited with Fiona Salvage, who presented her trophy as the winner of the C+D Pharmacy Assistant of the Year 2008

CD08 AWARD WINNER

All in a day's work

Nursing's loss is pharmacy's gain. C+D Pharmacy Assistant of the Year 2008 Amanda Wells says she doesn't have the stomach for the more gory parts of nursing and chose pharmacy instead.

It is Mrs Wells's desire to help patients that clearly puts her in a league above your average pharmacy assistant. Her bubbly personality and genuine concern for her patients are apparent as soon as you meet her. And, if I needed more proof, while I'm visiting, a patient pops in with a box of chocolates to say thank you.

However, it's not just the customers who can make it to the pharmacy who are indebted to her. After taking it upon herself to contact local care and residential homes to see if they would like a visit, she now goes to a number of homes with products for the residents to buy and order. Scores of elderly customers in nearby nursing and residential homes look forward to Mrs Wells's visits to take their orders for OTC medicines and, before Christmas, gifts. Mrs Wells has kept up the visits, even after her colleague who used to visit the homes with her left the branch.

Her commitment to her patients and customers is truly outstanding. This year, after taking their orders, Mrs Wells wrapped all the gifts, adding bows and tags, as a free service. It really made a difference to her customers, who told her: "I don't have to give them money this year, because I can pick my own gift."

Services within the pharmacy are still important though, and smoking cessation is a key offering as it means another new window display – something else Mrs Wells is proud of. The window displays are so good that last year's display, which showed the negative effects of smoking, was runner-up in her PCT's competition, winning the pharmacy a bottle of Champagne.

Other services on offer include Lipotrim weight loss, blood pressure monitoring, pregnancy testing, passport photos and most recently diabetes testing – something Mrs Wells has been pushing for for a long time. And does she like offering these services? "Love it. You've got that one-on-one with a patient in here [the consultation room], all private and confidential."

Thinking back to the C+D Awards evening, it was an evening of mixed emotions and a "really exciting night". Not only was Mrs Wells up for the assistant of the year award, but her Day Lewis colleague and friend Pamela Cook from the South Norwood branch was shortlisted too. Both ladies were rooting for each other and Mrs Wells was so shocked to hear her name read out. "I won and it was just 'wow'! Nothing like this happens to me so it was just amazing!"

Mrs Wells's husband was also ecstatic: "He was jumping for joy and screaming and I got the biggest hug in the world! He was so proud of me!" By the time she reached the stage, Mrs Wells was shaking like a leaf and couldn't think of a thing to say to the video camera.

Mrs Wells and her other Day Lewis colleagues who were either winners, finalists or had received certificates of merit were then plastered across the company's intranet, featured in the company's internal magazine and she was praised by Day Lewis CEO Kirit Patel at the company's annual conference.

So what's her advice for other assistants who are thinking about entering? "Go for it. If they've got something to offer the community out there and they can show it, then go for it. You'll shake like a leaf but it's well worth it! Have a go!"

Amanda Wells's file

Name: Amanda Wells

Pharmacy: pharmacy assistant and branch manager at Day Lewis, Erith

Award won: Pharmacy Assistant of the Year 2008

Award entry: She has taken the pharmacy to the residents of local care and nursing homes, created award-winning window displays, organised a charity raffle with local businesses, helped deliver pharmacy services such as blood pressure monitoring, contraception, Lipotrim and pregnancy testing.

Entries for the **C+D 2009 Pharmacy Assistant of the Year** category, sponsored by P&G Pharmacy Care, are now open. Go to **www.chemistanddruggist.co.uk/awards** for full entry details, hints and tips, online entry or to download an entry form.

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Open Mike — Mike Hewitson

The not-so-secret diary of a new pharmacy owner

Mike Hewitson is a glutton for punishment. In the midst of economic downturn and with first-time fatherhood looming, he bought his first pharmacy in deepest, darkest Dorset – 100 miles from his former home in Cheltenham. In this regular column, follow Mike's fears, frustration's and step-by-step successes as the new owner of Beaminster Pharmacy.

> "My last inspection was an absolutely terrifying ordeal"

While the rest of the country was in the midst of the annual "Why does the country grind to a halt when it snows?" debate last week, we had a visitor. It was a visitor we have spent the last four months waiting and preparing for: the inspector.

My last inspection was four years ago, and was an absolutely terrifying ordeal. This, I am pleased to announce, was nowhere near as painful.

The focus of the inspection was on our handling of controlled drugs, which was the first area that I had tackled after I took over – you have to be so careful these days to make sure that you are complying with best practice.

Luckily, before I left the security of employment, my ex-employer Dudley Taylor Pharmacies had spent a lot of effort doing the same exercise, which I felt had prepared me well for this task – thanks, Elaine!

Overall, the inspector seemed happy with our systems and felt that we were on the right track, which I was quite pleased with as it had taken a lot of hard work and effort to modernise our procedures.

Our next inspection, whenever that may be, will almost certainly be by the new GPhC, so who knows what that will bring?

1859-2009

Celebrating 150 years in pharmacy

C+D's October 1859 issue may lie a-mouldering in our archives but pharmacy's soul keeps marching on, PostScript has found.

The opening editorial of the issue brings to life the opinions of its readers and the range of issues that bothered them. Foremost was the Pharmaceutical Society, the subject of withheld letters that "contained attacks which appeared to us to be too severe". C+D's editorial staff still chipped in with their own thoughts, though, slamming the Society's Council and stating that their experience was "not calculated to raise our opinion of their freedom from cliquism... nor indeed of their attributes as gentlemen".

Harsh words indeed. PostScript wonders what C+D's first editor would have had to say on the future professional body...

Around the world in pharmacy systems

PostScript is confident globe-trotting pharmacists know where Tristan Da Cunha sits on the map, but admits it had to embark on a quick web search to find it. The volcanic island in the south Atlantic – accessible only by boat – has now received a helping hand in the form of an up-to-date pharmacy system from a Northern Ireland company.

Learning of the island's need for a pharmacy system after an acute outbreak of viral-induced asthma, Belfast-based McLernon Computers donated the software through NI-CO, an organisation financed by the Department for International Development.

The remote island's only doctor is scheduled to fly to Belfast in March to receive training on the system, which NI-CO said would highlight "the important role the pharmacist plays in the delivery of healthcare".

Web comment of the week

Tory MP condemns government over category M
Posted by Paul Badham on 06/02/2009, 11:58

> When will government **realise** devolving pharmacy services through the PCT **doesn't work?** Further health **checks** must be funded centrally if pharmacy has any hope of moving **forward** clinically

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Springboard

Springboard Pre-registration Training Programme

The **Medway School of Pharmacy**, in partnership with **C+D**, is launching **Springboard**, an exciting new pre-registration training programme. **Springboard** will cover all aspects of the community pharmacy experience and assist the trainee in making a smooth transition from student to professional.

The programme will consist of eight in-house study days covering:

- Responding to symptoms
- Law and Ethics
- Controlled Drug regulations
- Medicines use reviews
- Drug Tariff
- Pharmaceutical calculations
- Dressings and wound management
- Monitored dose units
- Smoking cessation
- Drug misuse
- Management
- Communication skills
- First aid
- The NHS and how it works
- Influencing your PCT
- Auditing your services
- Clinical cases using the BNF
- Practice exam questions

The programme will enable the student to meet the appropriate competences in the RPSGB pre-registration student handbook, and will offer support to pre-reg tutors. There will also be a tutor training day. Students will have access to a member of staff at the university and the university's facilities.

This programme is unique in that the students will have the opportunity to be accredited to provide medicines use reviews. Additionally students will be able to accumulate credits by completing distance learning courses included in the programme that can be put towards a postgraduate qualification.

All eight student study days and the tutor day will be held at Medway School of Pharmacy in Kent.

For more information on the **Springboard** course, complete the slip below and return to:
Pauline Sanderson, C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE

☐ **YES**, please send me more information on the **Springboard** pre-registration training programme

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Panadol is a trade mark of the GlaxoSmithKline group of companies.

Reference:
1. Wilson C *et al.* Abstract PH 217, International Association for the study of Pain 12th World Congress on Pain, Glasgow, Aug 2008.

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*In the stomach